Name _____ Date _____

Please circle all that apply

1. **Complaints:**

   Skin Lesion(s)/Growths Rash Discoloration Pimples/Acne Hair Loss

   Other (please specify) _____

2. **Where on your body?** _____

3. **Duration/How long have you had this?** Days ____ Weeks ____ Months ____Years ____

4. **Describe symptoms:**

   No Symptoms Bleeding Changing Color Enlarging Irritated Itchy New

   Not Healing Painful Spreading Swollen Burning Flaky

   Color: Black/Blue/Brown/Gray/Pink/Purple/Red/White/Multi-colored

   Hair loss: Diffuse Focal Generalized Scarring

   Pimples/Acne: Blackheads Whiteheads Pimples Cysts/Nodules Scarring

5. **How severe is your condition:** Mild Moderate Severe

6. **What makes your condition worse or better?** _____

_____

7. **Has your condition been treated?** Yes or No

If so, specify treatment _____

8. **Is this a new problem or a follow-up?** _____

9. **Other symptoms:**

   Chills, Fever, Cough, Diarrhea, household members with similar rash, starting new medication, recent illness, recent hospitalization, recent surgery, weight changes, anemia, hair relaxer, hot comb, hyperthyroidism, hypothyroidism

   Other, please specify:

   _____